PAYMENT AND REMITTANCE ADVICE /COVERED FUNCTION ISSUE

Review and Discussion of the applicability of the transaction to DSHS' programs.

Questions and Short Answers:

(1) What qualifies as a remittance advice?

Information about the transfer of payment.

(2) Are all payments of health services required to be accompanied by a remittance advice? No.

(3) What parts of our plan conduct that transaction currently?

(4) What parts of the plan will conduct the transaction after HIPAA?

(5) For our paper only payment process (A-19), where will an electronic remittance advice be generated if a provider requests it?

Background:

The health care payment and remittance advice transaction (835) is used to make payment and/or send an explanation of benefits remittance advice from a health care payer to a health care provider or through a depository financial institution.

HIPAA defines a Health care payment and remittance advise transaction (835) is the transmission of either of the following for health care:
  (a) transmission from a plan to a provider's financial institution of payment, information about the transfer of funds, or payment processing information; or
  (b) transmission of either from a plan to a provider: explanation of benefits or remittance advice.

In a typical health payment situation the payment/ RA occurs when:

  a) the check or EFT request is sent to the provider or provider's bank; or
  b) the checks are matched with a remittance advice or EOB generated by the health plan and then sent to the provider
  c)

Issue:

Which programs/systems handle payments and adjustments to payments?
Which programs/systems have information needed for the Remittance Advice?

<u>Analysis</u>:

<u>Definitions.</u>   HIPAA defines a health plan as any group or individual that pays or provides the cost of medical care. HIPAA defines a health care provider as an entity that provides, bills, or is paid for health care in the normal course of business. (Covered providers must transmit electronic transactions). Health care is very broadly defined as care, services, or supplies related to health of individual and includes preventive, diagnostic, assessment, maintenance, rehabilitative, counseling service, or procedure which respect to the functional status or affects the structure or function of the body, and drug, devises and equipment in accordance with a prescription.

<u>Transaction Roles.</u>   Health plans pay health care providers for health care services. Health plans send providers information about the payment. Information may include the invoice for which payment is being made, the service(s) or claims paid or denied, payment withheld information, etc.

<u>HIPAA Requirements.</u>
Health plans must have the capacity to accept and send electronic, HIPAA compliant (835) payment and remittance advice. A provider has the right to request electronic remittance advice instead of receiving paper remittance advice.

Pg 50334: The implementation specifications contain two parts, a mechanism for the transfer of dollars and a mechanism for the transfer of information about the payment, and allow these two parts to be transmitted separately. …Actual payment may be sent in a number of equally acceptable ways including check, and several varieties of electronic funds transfer… The standard allows transmission of one or both parts through a financial institution, but does not require both parts to be sent to the financial institution and the financial institution is not required by this regulation to accept or forward the transactions.

Pg 50334: A health plan can choose to continue to send paper RA notices to providers that are issued 835 transactions. However, all info that could have been expressed on the RA must be included in the 835.

<u>Capacity System</u>: DSHS sends remittance advice currently.   Thus, DSHS must have the capacity to send electronic RAs in a HIPAA compliant way. In order to send electronic RAs the must contain or receive information about the amount paid, and any amounts withheld.

<u>Additional systems</u>: If external payment systems send information about payment, the E-RA could be generated by that system.

<u>Internal Impact</u>: Data relating to the amounts paid, and reasons why/why not would need to be contained or fed to the system sending RAs.
If deductions are made due to overpayments, then the remittance advice needs to contain a code that explains why the deduction was made. The program that sends out the remittance advice needs to have that information. And the

payments need to true up. Some programs may have requirements about appeal rights notification or other notices that must be sent with payment, and may not be supported by the E-RA.

External Impact: Actual payment (check or EFT) is generally made by an external system. DSHS needs to receive data about the payment number to reference on the E-RA, or the external system may generate the E-RA.

Decisions and Consequences:

What information about payment needs to be sent to providers?
What systems can support the Electronic transfer of the payment information?
What other systems need the payment and RA information and when is it needed?

POLICY TAG DISCUSSION:

Practical implications:

General Discussion about the ability to split the transaction in to two pieces that can be sent separately or together. Notes above.

Question about what AFRS (system in other agency -OFM) receives from DSHS to process payment requests and what AFRS sends out to providers with their check or EFT.   Meeting with OFM representatives – they indicate a "remittance advice" is sent with each check. DSHS, also generates remittance advice for some providers - MMIS generates a paper RA which is matched up with a check in OFR.

ACES and SSPS may possibly send information directly to treasurer – bypassing AFRS/OFM.

On the payment recovery or with-holding side, we need to ensure that a reference number is sent on the initial notification that with-holding may be conducted. Then the RA will reference that number as an explanation of the reduced payment.   The implementation guide for RA appears to indicate that the number would be generated by the payer (not specified coding from a DSMO).